McGraw Wentworth

REFORM Update

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McGraw Wentworth's Health *Reform Updates* will be released every other week and will focus on key issues in the new legislation with special emphasis on issues faced by employers that sponsor health benefit plans.

At this time, we (and any responsible advisor) can provide only general guidance to most aspects of the two new Health Care Bills. Though the Bills total over 2,400 pages, in most cases they provide only overviews of new requirements - many important details simply aren't addressed in the legislation. Over the next months and years, we anticipate clarifying information from a number of sources including the IRS, DOL, and HHS in the form of administrative regulations, Q&As, and notices.

In our last *Reform Update*, we discussed required benefit changes effective on the first plan year following September 23, 2010 (for most plans January 1, 2011). In this *Reform Update*, we will review:

- **"Grandfather provision"** – when is an existing plan considered grandfathered and exempted or at least granted a delay in the effective date of specific provisions?
- Additional required benefit changes.
- Employer W-2 reporting requirements.
- Changes to non-discrimination requirements for health plans.
- Increase in excise penalty for non-medical distributions from HSAs.

Most of the issues above will need to be considered and addressed before year end, but until clarifying information is released you may want to hold off on developing detailed responses.

"Grandfather Provision"

The "grandfather provision" allows an exemption or delay in the effective date for additional required benefit changes in the two Health Reform Acts. So far, interpretations of the legislative language offer a wide range of possibilities from:

- Permanent exemption from additional changes for an ERISA plan established prior to March 23, 2010; to
- Delay in effective date for specific provisions of the health reform acts until grandfathered plan makes any design changes (note: regulations do state that benefit changes scheduled in collective bargaining agreements do not affect grandfathered status).

Understanding the grandfather provision will be critical for employers as it affects many of the new requirements in Health Reform. Many experts believe that even a minor benefit change may cause a plan to lose grandfathered status, but others have expressed opinions that any established plan will be grandfathered – this will be a critical issue to monitor as clarifying information is released.

Additional Required Benefit Changes

If your plan is grandfathered, the effective date of these provisions will be delayed, we believe, until the point your plan makes design changes. If a plan is not "grandfathered", additional benefit requirements must be adopted effective the first day of the first plan year following September 23, 2010 (for most plans January 1, 2011). They include:

- **Preventive care**: Health plans are required to provide 100% coverage for at least the following preventive health services:
  - Evidence-based services rated "A" or "B" in by U.S. Preventive Services Task Force.
  - Immunizations recommended by Advisory Committee on Immunization Practices of the CDC.
  - For infants, children, and adolescents: evidence-informed preventive care and screenings in comprehensive guidelines from Health Resources and Services Administration.
  - For women: preventive care and screenings not described in point 1 but provided for in comprehensive guidelines supported by Health Resources and Service Administration.
  - Current recommendations of U.S. Preventive Services Task Force regarding breast cancer screening, mammography and prevention shall be considered most current other than those issued in or around November, 2009.

  When a new recommendation or guideline is added, it may be added to coverage at the next plan renewal but cannot be delayed more than one year. It appears that employers can cover additional preventive services beyond those noted above. Finally, the government will develop additional guidelines to permit health plans to offer value-based insurance designs. No additional details are included on this topic.
- **Coverage of Emergency Services:** Health plans providing benefits for services received in an emergency room for treatment of an emergency medical condition, face new rules:
  - No prior authorization can be required.
  - Services provided by non-participating providers cannot face limitations more restrictive than limitations applying to participating providers.
  - Cost sharing requirements for services provided by non-participating providers cannot differ from those of participating providers.

  No mention is made if plans can base payments on in-network fee schedules, and whether the patient can be balanced billed if a non-network provider does not accept in-network fee schedule.

- **Designating a Primary Care Physician**: If a group health plan requires participants to designate a primary care provider, participants can designate any participating primary care provider in a position to accept such a patient. A physician (allopathic or osteopathic) who specializes in pediatrics can be named a child's primary care provider. If the plan covers obstetrical and gynecological services, the plan must allow direct access to an OB/GYN. The plan is permitted to require use of an in-network OB/GYN and the OB/GYN must adhere to the plan's policies and procedures including referrals or prior authorization, but cannot be required to notify the primary care provider of treatment decisions.
- **Coverage Appeals**: Health plans must establish both an internal and external review process. The current ERISA internal appeal process should already be familiar to employers with ERISA plans, but may be new to employers with non-ERISA plans (i.e., governmental employers). The Acts do make some modifications to current ERISA rules such as allowing claimants to present testimony as part of the appeal process. The external review rules reference the existing state level process typically applied to insurance carriers – fully insured plans may already be meeting this standard, but self-funded plans will need to adopt an external review process. More details will be needed to implement this process and most employers will need assistance from their insurance carrier or third party administrator to implement these requirements.

Employer W-2 Reporting Requirements

For tax years beginning after December 31, 2010, employers will be required to report the aggregate cost of employer-sponsored health plan benefits on each employee's W-2. The aggregate cost should not include contributions to HSAs, Archer MSAs or health FSAs. Benefits remain tax-free with the inclusion on the W-2 being made simply as a reporting requirement. Very few details have been provided and more will be needed to clarify how compliance will be accomplished.

Changes to Non-Discrimination Requirements for Health Plans

Section 105(h) of the Internal Revenue Code established non-discrimination requirements for self-funded medical plans that do not permit discrimination in favor of highly compensated individuals in eligibility or benefits under the plan. Health reform extends non-discrimination requirements of Section 105(h) to all employer group health plans - self funded and fully insured. Some employers avoided the requirements of Section 105(h) by providing enhanced benefits for highly compensated employees through fully insured plans. The change may also affect insured plans that offer different benefits to different classes of employees or different waiting periods to different classes of employees. The new rules are effective the first day of the first plan year following September 23, 2010. **Importantly,** it appears the effective date of this change may be delayed if the plan meets the grandfathering provision.

More details on the Section 105(h) non-discrimination requirements can be found in our 2006 *Benefit Advisor*, Issue 9 at http://mcgrawwentworth.com/Benefit_Advisor/2006/BA_Issue_9.pdf.

Employers should review their plans to determine if they may have a Section 105(h) discrimination issue. Penalties appear substantial - a new $100 per participant per day excise tax for a discriminatory plan. In the initial 105(h) rules, highly compensated individuals lost tax-favored status under a discriminatory plan; it is unclear if this penalty remains in addition to the excise tax.

Increase in Excise Penalty for Non-Medical Distributions from HSAs

Health Reform made only one change to HSAs. The excise penalty for non-medical distributions from HSAs increases from 10% to 20% for distributions made after December 31, 2010. The penalty for non-medical distributions from Archer MSAs increased from 15% to 20% for distributions made after December 31, 2010.

In our next Health Reform Update, we will cover the employer "pay or play" option that will affect employers in 2014.

Corrections: As Health Reform is complex and our understanding is evolving, we have added this corrections section to address issues where we believe our information may have been incorrect.

In Update #1, we communicated the incorrect effective date for the High Risk Pool – they are to be established within 90 days of March 23, 2010.